PRINTED: 10/12/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	C 10/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID I	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS On September 28, 2007 at approximately 10:30 AM the State Agency received an e mail concerning the care and treatment of the clients as described below: 1. Qualified Mental Retardation Professional (QMRP) current monthly reports as of September 19, 2007 were dated July 2007; 2. Primary Care Physician ' s progress notes dated May 29, 2007 indicated " poor oral intake with negative GI work-up ... consider possible PEG; " 3. A review of [Client #2] weight log revealed that weight has been stable, and gained one to two pounds since March 2007; 4. Only one of the four clients whose records were reviewed revealed that regular community outings were provided during the months of August and September 2007; and 5. Clinical therapy recommendations were not implemented. For example, there was no evidence that the client was provided beverage and water to him between meals was implemented; there was no evidence that client #1 physical therapist ' s recommendation for Client #1to lie in a prone position for ten minutes a day, three days a week was implemented Client #1 was not wearing his biker ' s gloves, as recommended by his psychologist; and Client #3 had not been using his communication device, as recommended by his speech therapist. Client #3's communication device was reportedly "not working" for the past two months. The findings of the investigation were based on	I 000		

Health Regulation Administration

Nancy Branch — DRS — 10/19/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 000	Continued From page 1 observations at the group home and one day program, interviews with group home and day program direct care staff, nursing and administrative staff, and review of client and administrative records; including incident reports.	I 000		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The finding includes: (See Federal Deficiency Report Citation W120)	I 500	**3523.1 Resident's Rights** See Federal Deficiency Report Citation W120	10/30/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 000	INITIAL COMMENTS On September 28, 2007 at approximately 10:30 AM the State Agency received an e-mail concerning the care and treatment of the clients as described below: 1. Qualified Mental Retardation Professional (QMRP) current monthly reports as of September 19, 2007 were dated July 2007; 2. Primary Care Physician ' s progress notes dated May 29, 2007 indicated " poor oral intake with negative GI work-up ... consider possible PEG; " 3. A review of [Client #2] weight log revealed that weight has been stable, and gained one to two pounds since March 2007; 4. Only one of the four clients whose records were reviewed revealed that regular community outings were provided during the months of August and September 2007; and 5. Clinical therapy recommendations were not implemented. For example, there was no evidence that the client was provided beverage and water to him between meals was implemented; there was no evidence that client #1 physical therapist ' s recommendation for Client #1to lie in a prone position for ten minutes a day, three days a week was implemented Client #1 was not wearing his biker ' s glove as recommended by his psychologist, and Client #3 had not been using his communication device, as recommended by his speech therapist. Client #3's communication device was reportedly "not working" for the past two months.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Branch | TITLE: DRS | (X6) DATE: 10/18/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 An investigation was conducted on October 9, 2007 to verify compliance with the basic standards of practice and ICF-MR regulatory requirements in active treatment and client protection. The findings of the investigation were based on observations at the group home and one day program, interviews with group home and day program direct care staff, nursing and administrative staff, and review of client and administrative records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that outside services met the needs of one of four clients in the sample (Client #1). The findings include: On October 9, 2007 Client #1's day program case manager was interviewed at 12:06 PM and revealed that the client's behavior interventions as prescribed by the client's primary care physician had not been implemented. It should be noted that the failure to implement the prescibed intervention may have resulted in client injury as evidenced below: 1. Client #1 has a behavior of hand biting and was prescibed "hand mitts or biker's gloves to be worn for 1 hour during exhibitions of self[self	W 120		

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W 120	Continued From page 2 injurious behaviors] to prevent injury." The day program's case manager revealed that the client had a pair of white gloves and presented them for validation. The case manager stated that the client did not wear the gloves because the day program did not have a physician's order. Review of Client #1's September 2007's physician's order at the day program however, prescribed "hand mitts or biker's gloves to be worn for 1 hour during exhibitions of sib [self injurious behaviors] to prevent injury." It should be noted that the physician's order revealed that the start date for the mitts were May 12, 2005. According to the day program case manager, the client had previously worn the gloves when he exhibited sib behaviors a "long time ago." 2. Review of the client's day program habilitation record on October 9, 2007 revealed a Behavior Support Plan (BSP) dated November 14, 2006. The plan documented "Behaviors of Concern" to include sib (hand -biting). It stated that Client #1's hand-biting behavior had resulted in serious wounds to the client's hands in the past and that the residential provider had implemented the use of a hand-mitt to prevent injury. Further review of the plan revealed that the day program failed to incorporate the use of the gloves recommended as part of an intervention strategy for his hand-biting behavior. The surveyor was told that when the client exhibits the hand-biting behavior, the day program staff are instructed "to ask [the client] to stop in a calm way. If he does not stop we explore why he won't stop. For example, if he is hungry, then we address his needs to eat. 3. Behavior data was requested from the day program for the months of August and September 2007. The case manager informed the surveyor	W 120	**W120** **This Standard will be met as evidenced by:** 1. QMRP will consult with the behavior specialist at the residential and day program sites as needed further ensure implementation of client #1's behavior support plan. QMRP will follow-up on a monthly basis to ensure receipt of behavior documentation. QMRP will continue to complete routine visits to the day program and address issues and concerns as they arise. QMRP will coordinate additional training as needed with day program staff. 2. Client #1's behavior program does include proactive strategies to redirect client #1 and to stop biting his hands. If the hand biting continues and/or redirection is unsuccessful, the gloves should be placed on his hands. QMRP will follow-up as indicated to ensure that the day program incorporates the use of gloves as part of an intervention strategy to address hand-biting. 3. Reference response to W120 #1 and #2. 4. Reference response to W120 #1 and #2.	10.30.07 ongoing

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W 120	Continued From page 3 that he would check to see if the data was available and if so, he would fax it to the state agency. [The behavior data for September was received post survey and reviewed zero incidents of hand-biting.] He further noted that the behavior data might be with the Behavior Specialist who was not at the day program facility on a daily basis. 4. Interview with the facility's house manager and review of records on October 9, 2007 at 6:34 PM revealed that the day program informed the facility (via "Intra-Agency Communication" form) on October 4, 2007 at 2:20 PM the "consumer exhibited his behavior" The form revealed that the client bit himself right hand which had an old wound. Observation of the client's hand by the house manager on October 4, 2007 revealed that the hand was red. Interview with the day program staff revealed that the glove was not being used during the incident.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS' RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to document actions taken to ensure the right of each client and/or legal guardian to be informed of the attendant risks of treatment and the right to refuse	W 124		

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W 124	Continued From page 4 treatment, for one of the four clients in the sample. (Client #1) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) via telephone revealed that Client #1 had been approved for a guardian in April 2007. Further interview with the QMRP revealed that he would fax a document that provide evidence of guardianship. Interview with the House Manager revealed that Client #1 did not have the capacity to give Informed consent for the use of his medications, habilitation services, and finances. The interview was verified by the client's psychological assessment, dated July 5, 2007. According to the assessment, Client #1 "does not evidence the capacity to make independent decisions on his behalf regarding his habilitation planning, treatment, placement, financial and medical matters." Further interview with the QMRP on September 27, 2007, at 4:01 PM, revealed that the client had family involvement (mother) but did not have a legal guardian. Interview with the QMRP and review of Client #1's records failed to provide evidence that Informed consent was obtained for the use of the client's hand mitts. At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, including the benefits associated with the use of intervention, and the right to refuse treatment, had been fully explained to him and his mother.	W 124	**W 124** **This Standard will be met as evidenced by:** QMRP will fully explain to client #1 and his mother the use of interventions to include risks/benefits of treatment, and the right to refuse treatment. QMRP will obtain written informed consent from client #1 and his mother. Information will be filed in client #1's book for review.	10-30-07 ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

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W 159	Continued From page 5 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interviews and record review the Qualified Mental Retardation Professional (QMRP), failed to ensure that client's active treatment program to include interventions were established, integrated, coordinated and monitored for one of four clients included in the sample. (Client #1) The finding includes: The QMRP failed to ensure that Client #1's treatment orders for hand mitts or lockeds gloves to be worn for 1 hour during exhibitions of self-injurious behavior(sib) to prevent injury was incoporated in his day program Behavior Support Plan (BSP). [See W120]	W 159	**W159** **This Standard will be met as evidenced by:** Reference response to W120. QMRP will review and discuss client #1's behavior support plan with the behavior support specialist/s. QMRP will follow-up to ensure that client #1's behavior support plan is integrated, coordinated and monitored on an ongoing basis. QMRP will also follow-up to ensure that physician's orders remain consistent with behavior support interventions at both the day program and residential settings.	10/31/07